MDR: M4-02-2711-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 4-11-01.
   b. The request was received on 3-21-02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter requesting Medical Dispute Resolution
   b. UB-92
   c. EOB
   d. Medical Records
   e. Healthcare Network participation and service agreement dated 7-30-92
   f. State Office of Administration Hearing decision (SOAH), dated 09/04/02
   g. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. Response to a Request for Dispute Resolution
   b. Methodology
   c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. As reflected in the Commissions Dispute Resolution Information System Case Activity Log (sequence #10), the letter requesting additional information was faxed to the Requestor on 10-17-02. Additional information was due on 10-30-02. Requestor's additional information was submitted on 11-5-02. Both copies were sent to the Waco Medical Dispute Unit. One copy was sent back to Austin on 11-6-02 and should have been received on 11-7-02 where it would have been placed in the carrier's box. The carrier's response was received on 11-22-02. No carrier sign sheet was noted in the dispute packet. All information will be reviewed and utilized in the writing of this decision.

III. PARTIES' POSITIONS

1. Requestor: Requestor: Letter dated 11-4-02:
"The Carrier provided individual payment exception codes of 'M' for *each* line item of billed charges. However, several of the billed charges had a maximum allowable reimbursement per the TWCC Fee Guidelines and were not reimbursed by the Carrier for the 'MAR' amounts. Further, the Carrier has inconsistently reimbursed for billed charges with a corresponding 'MAR.' Specifically, the enclosed EOB's evidence that the Carrier does reimburse per the TWCC Fee Guideline for billed charges, which have a 'MAR,' but the Carrier has not done so in this instance. Therefore, the Carrier's application of 'M' for each billed item is not in accordance with the Texas Administrative Code and the Commission's instructions and the **requestor is entitled, *at the minimum,* to the fee guideline reimbursement amount for billed items which have a 'MAR' per the TWCC Fee Guideline….** (Requestor) charges the above-referenced services at a fair and reasonable rate. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by (Requestor) is at a minimum of 70% of billed charges. This is supported by a managed care contract with '…' that is attached as Exhibit 1".

2. Respondent: Letter dated 11-21-02:
"This dispute involves the carrier's payment for date of service 4/11/01. The requester billed $4946.47; (Carrier) paid a total of $618.00. The requester believes it is entitled to an additional of $3967.47. 1. There is no MAR for outpatient ASC services….7. (Carrier's) payment is consistent with the fair and reasonable criteria established in Section 413.011 (b) of the Texas Labor Code….In this dispute (Carrier) took the CPT code used by the surgeon, 22505 (manipulation under anesthesia), and applied its methodology to determine its fair and reasonable payment of $618.00. No further reimbursement is due."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 4-11-01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $4,946.47 for services rendered on the date of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $618.00 for services rendered on the date of service in dispute above.

5. The Carrier's EOBs denied any additional reimbursement as "M – OPSR No Mar". Both the Requestor and the Respondent have indicated that the disputed issue is in regard to a fair and reasonable denial.

6. The amount in dispute is $3,967.47 for services rendered on the date of service in dispute above.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgery center. Commission Rule 134.401 (a)(4) states ASCs, "shall be reimbursed at a fair and reasonable rate…"

Section 413.011 (d) of the Texas Labor Code states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fees charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The Commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;"

The carrier, according to their position statement, asserts that they have paid a fair and reasonable reimbursement. The carrier indicates in their methodology that two national resources are utilized in determining a fair and reasonable reimbursement, "….ASC charges as listed by CPT code in '1994 ASC Medicare Payment Rate Survey and ASC Group payment rates as determined by the Secretary of the U.S. Department of Health and Human Services for surgical procedures by CPT code….(Carrier) used this data in the following manner: 1) The payment rate for the service in dispute, as defined by the CPT code, is determined using Medicare's ASC Group rates. 2) The median charge from ASCs, weighted by total volume, is determined for the service group. 3) The co-payment amount is determined by multiplying the median weighted facility charge by 20%. 4) The dollar amounts from B.1) and B.3) above are summed to determine the fair and reasonable payment for the service." The carrier then took the CPT code 22505 used by the surgeon and applied the above methodology to arrive at $618.00.

As the requestor, the health care provider has the burden to provide documentation that "…discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." pursuant to TWCC Rule 133.307 (g) (3) (D). The provider has submitted a letter discussing the justification of their charges. The discussion indicates that under a managed care contract, (Requestor) will accept 70% of the billed charges. The provider states, "The amount of reimbursement deemed to be fair and reasonable by (Provider) is at a minimum 70% of billed charges. This is supported by a managed care contract with '…' …."

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. In this case, the Requestor has included as an exhibit a copy of an agreement between Requestor and "…". This agreement alone does not discuss, demonstrate and justify that the payment being sought is fair and reasonable as required by TWCC Rule 133.307 (g) (3) (D). However, the Respondent has submitted a methodology that supports their position that the amount reimbursed represents a fair and reasonable reimbursement. Therefore, **no additional** reimbursement is recommended.

The above Findings and Decision are hereby issued this 14th day of February 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll